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Healthy Community Indicators: Lessons from the Social Indicator Movement

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1. Introduction

Interest in social indicators has expanded and contracted in the last thirty years. There was a peak of activity in the late sixties which tapered off in the 1970s with a brief revival in the late 1980s. The social indicators literature is reviewed in this paper as a possible source of enlightenment in the new search for healthy community indicators. The potential of the social indicators' literature to inform the quest is explored from several perspectives: first to examine the definitions of social indicators and their relationship to health indicators; second, to extrapolate the lessons learned from the social indicators movement; third, to provide examples of current sets of health and social indicators; and finally, to indicate implications for healthy community planners.

In the past, social indicators were called upon to explain the relative lack of success in the American War on Poverty. A United States commission established in 1964 made several recommendations to improve public decision making including that the government create a "system of social accounts" which would indicate the social benefits and social costs of a product" (Land and Spilerman, 1975:6). This approach

idealized the contribution of science to the resolution of social problems by assuming that improved methods of quantifying would yield the right answers.

A similar momentum appears to be responsible for the revival of interest in social indicators. Increasingly practitioners, policy makers, academics and the public are aware of the interdependence of individual acts and their impact on health, for both individuals and the environment. Examples such as the movement to eliminate unnecessary use of styrofoam cups, recycling, and biodegradable cleaning agents are motivated by this encompassing view. Proponents of behaviour changes argue that the long-term costs of pursuing convenient short term goals will create tremendous social burdens.

The potential of the social indicators movement to assist in the development of healthy community indicators is related to this interdependent view of health. Health defined broadly as a "resource for control over one's life" (WHO, 1986) has demanded that the measurement of health include environment, access to health care services, lifestyle, and biological factors. The additional layer of community has meant that there is a need for reconceptualizing the relation-



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ships between these factors in a community context, and indeed for redefining what measures are appropriate to evaluate the health of a community. The conceptual overlap of health indicators and social indicators is inevitable as it reflects that health status of individuals is affected by the community in which they live. And, certainly there is a reciprocal relationship between the community and the individuals who compose the community. The challenge has been to create, define, and locate indicators which are able to disaggregate the impact of these factors on the health status of individuals while at the same time respecting the interaction effects of the same factors in a community context.

2. Social Indicators: Definitions

A variety of professionals including administrators, educators, policy-makers, and practitioners have been involved in developing social indicators each from their unique perspective and need for the information that the indicators yield. Not surprisingly, a number of ambiguous definitions have been proposed. Carley (1981: 29) suggests that one universally accepted definition is "hardly likely."

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The point is not that one definition is essential but rather that the definitional process causes a critical examination and re-examination of the essential concepts of social indicators."

The World Health Organization (WHO) simply defines a social indicator as a "variable which helps to measure change" (WHO, 1981a). Social indicators themselves are one category of health indicators. WHO identifies four categories of health indicators: health policy indicators; social and economic indicators; indicators for the provision of health care; and indicators of health status and quality of life. One of the more commonly accepted definitions of a social indicator is the one used by the Organization for Economic Cooperation and Development: "a direct and valid statistical measure which monitors levels and changes over time in fundamental social concern" (OECD, 1973).

The goal of measuring change from a health perspective is made more complex by a lack of consensus about the parameters of health. For instance, if we are to take seriously the WHO definition of health as 'physical, mental and social well-being' there must be a correspondingly wide understanding of the factors that affect health. The boundary issue for researchers, policy makers and planners is of central concern, particularly when attempting to measure the dynamic concept of health field. A related problem is how reliable and valid are the measures when they emanate from such a broadly defined concept. As Goldsmith (1972: 214) notes, cost of gathering these data may be substantial.

"How many states, cities or other political subdivisions could afford to spend... money to get questionably valid data about poorly defined concepts for often incomprehensible purposes?"

Undaunted by these formidable constraints, some researchers have continued to produce indicators. These indicators may be regarded as both *surrogates* and *measures*. As surrogates, social indicators are used to translate abstract or unmeasurable concepts (such as safe streets) into operational terms (such as

numbers of days without car accidents) allowing consideration and analysis of a particular subject. As measures, social indicators deal with information that is conceptually quantifiable. Social indicators usually consist of five parts. For example, consider the annual infant mortality rate in Alberta. This indicator involves a period of time (a year), a place (Alberta), a subject class (infants), a property of members of that class (mortality) and a statistical measure (rate per 1000 births).

Social indicator researchers tend to categorize indicators on the basis of whether they represent objective or subjective measures of reality. Objective conditions are measured by counting occurrences of a given phenomena on an interval or ratio scale. On an individual level, the measurement of health is associated with diagnostic or laboratory tests. Subjective measures of health include those that record general feelings of well-being or satisfaction with life, and those that emphasize the functioning of an individual (McDowell & Newell, 1987). These latter measures reveal insights into matters of well-being that could not be inferred otherwise from physical testing.

Although by nature health indicators based on subjective judgements are difficult to measure and to compare, use has become more prevalent. Epidemiologists tend to rely heavily on the use of objective indicators to measure health, while those interested in measuring quality of life use subjective indicators. Others involved in developing broader social policies recommend a combination of subjective and objective indicators within a systematic framework (Carley, 1981).

For example, the determinants of health matrix presents a way of looking at both subjective and objective functioning within an individual context. The matrix is a variant of Norman White's disease/illness model (1983).

The upper right hand quadrant represents an individual who is objectively healthy and lives in a community with adequate income to purchase shelter, food, clothing, has adequate social supports and positive social relations. The lower left quadrant represents an individual who is not healthy, ie. has an identifiable disease, and does not have adequate economic, social or political supports in their community. In adapting this model to the community one might suggest that communities may have several indicators of poor health such as proximity to industrial sites that pollute, higher morbidity rates, high unemployment, low social-economic status but may have several positive aspects such as community participation in local issues, organizing committees for cleanup, active participation in local government, and good interagency collaboration for example.

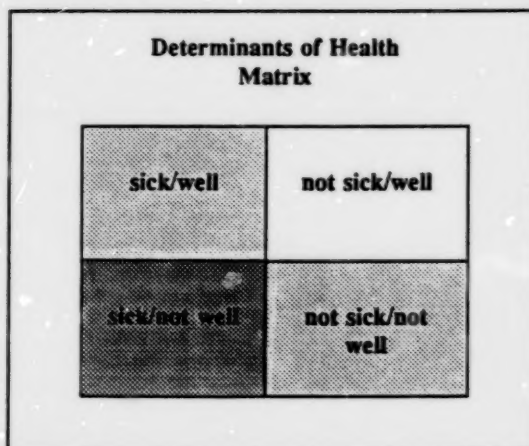
In this case the community might fit into the sick/well quadrant. Likewise, a community where there is adequate income security and lower social support mechanisms dispersed throughout the community, with fewer opportunities for local control by citizens may be designated not sick/not well.

This attempt to discriminate between process and structure, social health and physical health, is not

unlike earlier attempts to separate social indicators from social accounts as previously defined. Wilbur J. Cohen distinguished between the two as follows:

"We need... statistics which will help policy makers identify and measure problems, and statistics which will help them decide how best to use the available resources to solve these problems" (as quoted in Land and Spilerman, 1975: 10).

Development of typologies to organize social indicators into categories which allow researchers to estimate social system processes and health and social outcomes have been frustrated by the lack of precision or



understanding of the relationships between process and structure. For example, the presence of food banks in a community may indicate several things simultaneously. It may mean that:

- 1) some members of the community have inadequate income to purchase basic goods such as food;
- 2) there is a degree of altruism and activism in the community to provide for the needs of others;
- 3) there is an inadequate response to the needs for basic goods for individuals and their families by the welfare state; and/or
- 4) the degree of altruism present in the community has not extended to remedy the root cause of the problem, merely the symptoms.

As in the quest for social indicators, the task appears to be to find a set of social statistics which are neither too inclusive nor too exclusive, and yet allow for decision making about the quality of life in a community and point the direction for remedying communities which are not well or sick. The application of the test for social indicators as described by Cohen above would not necessarily provide information for decision-making in the case of food banks. The decision would depend on the weights assigned to the social costs encountered by users of the food banks and normative standards of equity for the community which developed the food bank. A legitimate question is then, what are the uses of social indicators?

3. Uses of Social Indicators

Four categories of potential use for social indicators have been identified by Michalos (1980: 12 - 17). The primary use is issue identification which allows for the assignment of certain values at a point in time to be compared over time against an established standard. The object of the data collection procedures are intended to assist policy makers to set priorities for policy and programs. Using the foregoing example of food banks, the objectives may be to establish the number of food banks in a certain community, the number of persons served, turnover rate of users, a profile of users and their alternate forms of support, the average food bag contents, the weekly donation rate by the community, source of support both financial and

human capital, and the size of the budget, staff, and physical plants involved.

A second use is the construction of baseline surveys which includes background information to assist in planning and decision making. These can be viewed as a snapshot of a community at a given point in time, or take an historical perspective. A community profile is an example of a baseline survey. In the food bank case, a community profile would include information about how the community came to identify the problem that required a food bank solution, the nature of the community that the food bank serves and those who do the serving, as well as basic demographics on population, income distribution, employment rates, family status and density for example.

Monitoring trends is a third use for social indicators and can facilitate comparisons between countries, regions, cities and neighbourhoods over time. Trends already noted can be used to infer future values for the specific indicator. For example, in the food bank study, one might track use over time, the rate of growth or decline and from the past trends, predict future usage.

Finally, evaluating or estimating the effect of government policies or programs or assessing the social impact of large projects are further examples of how indicators are used. In the food bank study one would be interested in assessing the impact of the food bank on the health and well-being of users and those who gave to the foodbank, the impact on government policy, the relationship between the presence of the food banks and direct action to remedy the cause of the problem.

4. Lessons from the Social Indicators Movement

There are two major limitations to the use of social indicators. These are the theoretical and/or contextual limitations, and the methodological problems associated with their application in the real world. The efficiency of social indicators has been questioned in terms of the amount of time and resources required to gather the data and their effectiveness to assist in decision making. Advocates expected that the information

provided by social indicators would result in more rational public policy making on a range of social issues. This early over-enthusiasm led to unrealistic expectations about the capacity of the indicators to serve as a substitute for the difficult decision making process itself.

4.1 Theoretical Limitations

There are three main criticisms from the theoretical perspective of social indicators and their application to healthy communities: the inadequacy of the theoretical model used to explain the contextual factors; the assumption that social indicators are value neutral; and finally, the lack of precision in the definition of the healthy community concept.

Within the field of health promotion and healthy community indicators recent analyses have come to conclusions similar to McQueen and Noack (1988: 123) who note the problems of developing healthy community indicators include;

the role of the macro (broad social or environmental) perspective; the notion of a process as a property of health promotion; and the role of models and model building in articulating a theory.

Carley (1981) criticizes the social indicators movement for not being well-grounded in theory which can result in unsubstantiated causal relationships being implied. Indicators involve building a model of a social system as well as establishing a relationship between the indicators and the system being described.

As identified earlier, the presence of food banks in a community may be indicative of any number of things depending upon the paradigm employed to explain them. In the past there has been a tendency to side step model building and move directly into development of indicators, and as a consequence, data gathered may or may not be useful to understanding social issues.

The social indicators movement is part of a positivist tradition of knowledge. The tradition assumes that knowledge is measurable and that the views (and

values) of the observer do not influence the observed. Carley (1981) points out that value neutrality, one of the main benefits of social indicators according to its advocates, is impossible to achieve. The selection of indicators themselves shape the outcome. Gender, race, class and culture all affect the development of indicators and this bias must be made explicit.

The supposed value-neutrality of social indicators has led some advocates to assume that a technocratic solution to social issues is possible. This view ignores the existence of political agendas: "It is naive to claim that social indicators in themselves permit decisions on which programs to implement" (Land & Spilerman, 1975). Hayes and Manson Willms (1990), in a paper reviewing the search for healthy community indicators, note that there are a number of concerns including how the results from the data collection may be used either for or against communities.

Social indicators gather information that is interpreted in the decision-making process. The paradigm used to interpret their meaning is also affected by the values held by decision makers. The value of the data gathered is dependent upon the values that shaped the selection and interpretation of the indicators.

The apparent lack of precision in the healthy communities concept has meant that there have been no clear parameters to limit the field of study. The inability to so far define what variables should be included or excluded from the study of healthy communities has meant that the field is so broad it is in danger of becoming meaningless. If healthy communities mean that everything that happens within a community must be taken into account, then the task of assessing what is and what is not important to understanding a healthy community becomes overwhelming. As Ilona Kickbusch of the World Health Organization (Hancock, 1989) has warned, the healthy communities movement must avoid "healthism" where everything is defined as health or health related so that the concept becomes diluted at best and a black hole at worst.

Hayes and Manson Willms (1990) note the discrepancy between the notion of static indicators and the dynamic evolving state of community that is self-generated and defined. It is for these reasons that it is "most unlikely

that a set of 'one size fits all' indicators can be identified." The designation of the healthy communities concept as "fuzzy" may or may not be appropriate. In fact, what may be occurring is the transformation of the idea of healthy communities from one that is static to one that is elastic.

The definition of health as a resource for control over one's life suggests that the definition of a healthy community must mean that there is some control by the community over the assignment of what it means to be a healthy community. Community control means that the selection of indicators and the interpretation of the data gathered must be directed by the communities themselves. This requirement has obvious implications for comparability between communities when there are differences in processes and circumstances which give rise to the conditions operating in the various communities (Hayes and Manson Willms, 1990).

4.2 Methodological Limitations

There are a number of methods problems flowing from the theoretical problems. In the absence of a theoretical model, the specification of a model may be likened to floundering rather than grounding the application of the model to the issue for study. The inability to specify the model means that the decision about what variables to include or exclude is made in the absence of theory and as such, there is no evidence to support the inclusion or exclusion of one variable over another. The data collected may or may not be relevant to questions being asked. A salient criticism is that until the theory behind the question is understood, there are no relevant answers, just more questions.

The selection of indicators to fit into a research design may be the over riding methodological question, however, even if the design issues were settled, the measurement problems remain. As Michalos (1980:4) has noted, there are problems with validity.

In the best of all possible worlds, the relation between an indicator-value and what it indicates would be one to one. Every indicator-value would indicate only what it is supposed to indicate. In the real world, however, indicator values are about as well behaved as therapeutic drugs. They give you a little of what you want and expect, on

top of a lot that you don't want, can't use and didn't expect.

Reliability of the data is also a concern. The risk assessment literature has much to offer to methodologists concerned with instrumentation. Schrader-Frechette (1987) and Crane (1987) suggests that the margins of error that are acceptable to the scientific community at the five percent level are consistently violated by using instruments to gather data that vary significantly in their ability to deliver standard results over a variety of conditions. For instance, in a study of cancer incidents in Powell River, B.C., the author noted that approximately forty percent of the instruments used to collect the data were unreliable (Van Netten, 1989). The lesson here is that the technology used to gather information may or may not reliably produce the information that it was designed to collect.

Comparability is a further concern. Differences in social indicators between countries, regions or communities may reflect definitional variations and/or statistical errors, rather than real differences. The issue of standardization of indicators to facilitate international, regional or local comparison meets with resistance from those who advocate for community control of the definition, selection and interpretation of the data. In an international meeting of experts "the varying physical, social and cultural contexts of individual cities" made the common identification of indicators very difficult. (WHO, 1988b: 41)

Data collection procedures affect the quality of data gathered and highlight a concern for efficiency. Carley (1981) suggests that there is a trade-off between the utility of overly aggregated data which may hide important distinctions among groups or sub-classes, and unaggregated data, which is difficult to draw conclusions from and to synthesize. A balance must be struck between the simplistic approach and information overload.

Manipulation of the data where indicators are used selectively to support a particular point of view (Carley, 1981), hide a trend or create a social problem (Michalos, 1980) is a further issue. A related problem is the mistaken belief that the development of social indicators precludes the need for other forms of data. For example, the question of community involvement

in the needs assessment process or issue identification is not a central theme of the social indicator literature.

The cost of collecting data may be a barrier. Model building and data collection exercises associated with indicator development can be extremely costly. These may restrict their use to those with the resources to support the task. Decisions must be made regarding the trade-off between relying on existing or secondary data gathered for other purposes and collecting new data which is time consuming and expensive. Cost-cutting may result in inaccurate results or a paucity of data.

Finally, a related concern about resources. Who is appropriate to perform the data collection task? If the task is overly technical then experts may need to be involved restricting access to community groups that can afford them, and perhaps sacrificing community control.

5. Example of Current Healthy Community Indicators

The tone of the social indicators literature ranged from over-enthusiasm of the novitiate in the late 1960s and early 1970s to the outright despair over their inherent limitations in the 1980s. However, in the late 1980s a resurrected version of social indicators has reappeared under the guise of healthy community indicators. Below is a record of three current lists of healthy community indicators and information to date on the process of development and the progress in accepting them.

Internationally, the WHO European healthy cities movement has been instrumental in developing a preliminary list of 26 basic indicators for health. The Healthy Cities Indicators workshop held in Barcelona in March 1987 attempted to operationalize the indicators and to arrive at further examples based on the WHO (1985) Targets for Health For All 2000. The workshop results confirmed that the search for relevant, sensitive and easy to collect indicators is far from over. The indicators are grouped in seven categories (see Table 1) which cut across physical well-being of individuals and the community in which they live together and meet common needs.

It is instructive to compare to a similar list (Table 2) generated in *PIBC NEWS* (September 1989, 37). At first glance the list appears to cover the same territory. The subtle differences however, are instructive to explore. Compare Table 1, Indicator No. 26 with Table 2, Indicator No. 23.

In the first table, the indicator reads: 26. Standardized death rate due to AIDS or HIV positive tests per total number of tests performed. In the second, the indicator is: 23. HIV positive tests per total tests.

In the first case the question is about death rates, and in the second, the concern is about infection rates. While the subject area is similar, i.e., AIDS, the measurement statistics produced from one test will not be comparable to the other. The criticism here is that in order to be comparable the exact same measurement must be used and the data must be collected in a similar and replicable manner.

A second example is in the Rate of Reported Violent Crime (Table 2, No. 4; Table 1, No. 8). The *PIBC News* version is undefined, and the WHO indicator is defined by police. It is important to know how the crime is identified, by what standards and whether or not the police force uses the same screen for violence. One would also want to examine the political agendas extant in the identification of crime as violent. If the police force depends on these statistics for resource allocation the results may be different than if funding of police services was determined in other ways.

Barbara Lane (1989), in a study to develop a conceptual model for a Winnipeg Healthy Communities Project, reported on data availability and catchment area for the 33 indicators originally presented in Barcelona.

Over one-third did not have any data available and several more had data that was aggregated at a regional rather than local level. The missing pieces are, of course in the area that addresses matters of perceived well-being such as self-esteem measures and work satisfaction. Of the data that are theoretically available, only four indicators had information that was immediately available.

Table 1: Twenty-Six Basic Indicators for Health: WHO European Healthy Cities

Clean, Safe, High Quality Physical Environment	
1. Number of days per year with average acid pollution (NO _x , SO ₂) above WHO guidelines.	14. Incidence rate of salmonellosis (per 1000 population per year).
2. Perceived Annoyance Index. Composite index of noise, smell and dirtiness (the sum of 1-5 scores given to each of the 3 items) - to be developed.	Optimum Public Health and Sick Care Services
3. Percentage of substandard dwellings (defined according to the standards in each city)	15. Percentage of City budget devoted to public health for number of new health promotion activities to which resources are allocated.
4. Rate of reported violent crime (as defined by police).	High Health Status
5. Percentage of people reporting they feel safe walking at night in the neighbourhood.	16. Proportion of daily smokers in the population.
A Stable, Sustainable Ecosystem	17. Percentage of people reporting they have restrictions on smoking in their workplace (covers only the working population - to be developed).
6. Percentage of domestic waste recycled.	18. Percentage of reported motor vehicle accidents involving alcohol.
Mutually Supportive, Non-exploitative Community	19. Incidence of motor vehicle accidents (per population over 18).
7. Perceived accessibility to local shops.	20. Percentage of people reporting daily use of tranquilizers (or number of tablets of tranquilizers sold per adult population).
8. Self-perceived loneliness: percentage reporting loneliness often or always.	21. Self-esteem (to be developed).
9. Percentage of people reporting the city as a good or very good place to live.	22. Percentage of people reporting good or excellent health.
Public Participation and Control over Decisions	23. Average days of reported restricted activity per year.
10. Percentage of people reporting involvement in a health, social, peace or environmental group.	24. Perinatal health: rate of babies born below 2500 gr.
Meeting Basic Needs (food, shelter, income)	25. Potential years of life lost due to cardiovascular disease under the age of 70.
11. Working satisfaction (to be developed).	26. Standardized death rate due to AIDS or HIV positive tests per total number of tests performed.
12. Percentage of families without independent dwelling (as nationally defined.)	
13. Percentage of unemployment (as nationally defined) OR Percentage of families living below poverty line OR Percentage of population receiving welfare/social assistance OR Percentage of population receiving less than 50% of the average wage (national if no city average available).	

Source: From Mathur, Brijesh (1989) "Community Planning and the New Public Health," *Plan Canada*, 29(4) p.36.

The practical application of the theoretical concepts of indicators has proven to be difficult as demonstrated by the Winnipeg study (Lane, 1989). Across Canada, regional seminars are being organized under the auspices of Knowledge Development in Health Promotion to try to come to grips with these issues. In February 1990 the first Western Regional Workshop was held involving over forty participants from Saskatchewan and Manitoba and several national

experts to develop indicators for Canadian communities. The results of the first workshop are instructive. Three task groups were asked to develop subjective and objective indicators for the physical environment, the social environment and for the individual. While the first and last group were able to generate long lists of indicators for consideration, the group asked to produce indicators to measure the social environment were unable to produce a single agreed

Table 2: 26 Non-Traditional Measures of Health

1. %age of a families without independent dwellings.
2. %age of substandard dwellings (as locally defined).
3. %age of unemployment or %age on welfare %age receiving less than 50% of average wage.
4. No. of days per year with average acid pollution above WHO guidelines.
5. Perceived Annoyance Index (composite of noise, smell & dirtiness)
6. Perceived accessibility to shops
7. Self-perceived loneliness
8. Rate of reported violent crime.
9. Work satisfaction.
10. Proportion of daily smokers in the population
11. Self-esteem measures.
12. %age of reported motor vehicle accidents involving alcohol.
13. No. of new health promotion projects funded.
14. %age of domestic waste re-cycled.
15. %age of workplace with restricted smoking.
16. %age of population involved in health, social, peace or environmental groups.
17. %age of people reporting good or excellent health.
18. Average days of reported restricted activity each year.
19. Rate of babies born below 2500 grams.
20. No. of tranquilizers sold per adult population.
21. Incidence rate of salmonellosis / 1000 population / year.
22. Potential years of life lost due to coronary heart disease.
23. HIV Positive tests per total tests.
24. Incidence rate of motor vehicle accidents per population > 18 years.
25. %age of people reporting this City as a good or very good place to live.
26. %age of people reporting feeling safe walking at night in their neighbourhood.

Source: Twenty-Six Non Traditional Measures of Health (Sept. 1989) *Planning Institute of B.C. News*, 31(3) pp. 7-9.

Table 3: Healthy City Indicators: Original List From Barcelona Conference.

1. % of homeless families.
2. % of substandard dwellings.
3. % of unemployment
4. % of poverty.
5. # days/year NO_x/SO₂ levels exceed WHO guidelines.
6. Annoyance index (Max. = 15) (noise, cleanliness, no offensive smells).
7. % of seniors within 10 mins. walk of park/public open space.
8. % of people reporting "great difficulty" in physical accessibility to local food shopping.
9. % of people reporting "often" or "always" lonely.
10. Violent crime rate per 1,000 people.
11. % of people who report they have "fairly great" or "very great" control over the conditions that influence their health and the health of their family (if they have one).
13. % of people who are daily cigarette smokers.
14. % of people who report "fairly high" or "very high" level of self esteem.
15. % of traffic accidents involving alcohol.
16. % of people who report active self-care activity.
17. % of locations where smoking is banned/controlled (max. = 5).
18. Existence of an Interdepartmental Healthy Community Strategy group.
19. Mayor and/or Council have made public commitment to a Healthy Community strategy or project.
20. % of domestic waste recycled.
21. % of people reporting involvement in a health, social justice or environmental group activity.
22. % of people reporting "fairly good" or "very good" health.
23. Days of reported restricted activity (unable to do usual work or daily life activities) per person per year.
24. % of babies born weighing less than 2,500 gms.
25. % of 7 year olds fully immunized with Diphtheria, Tetanus, Polio.
26. Rate of Salmonella infections reported per 1,000 people per year.
27. Age standardized mortality rate for cardiovascular disease.
28. % of people reporting they feel safe walking at night in their neighbourhood.
29. % of people reporting the city is a "fairly good" or "very good" place to live.
30. City Council policy on accessibility for the physically disabled.
31. % of people reporting they daily experience anxiety, depression, sadness or extreme tiredness.
32. Potential years of life lost (after age 1, before age 70) per 1,000 residents (standardized).
33. Traffic accident mortality rate (standardized).

Source: Barbara Lane Table 1, 38-39 (1989) based on Hancock, T. *Healthy City Indicators*, March 26 1988 letter to Barcelona Colleagues.

upon indicator. Questions asked within the group were about indicators for what, for who, and how they will be used and interpreted. The experience was a valuable lesson for the academics, community leaders and bureaucrats present which reinforced the difficulty in trying to identify a "one size fits all" indicator.

6. Implications for Health Community Indicators

In attempting to illuminate the path toward the identification of healthy community indicators with the light from the social indicators movement, the astute observer will recognize the terrain as one where angels fear to tread. From twenty years of social indicator research, we know that the area is fraught with conceptual and methodological issues and that the resolution of these problems are value laden.

Encouraging the pursuit of the development of indicators was the main message of Michel O'Neill of the Université de Laval after spending a year with WHO Europe on the Healthy Cities theme. At the Western Regional Workshop in Winnipeg (February, 1990) he shared the benefits gleaned from experience. First, healthy community indicators do not work in the way in which we had hoped; second, multi-disciplinary teams need time to sensitize each other to spheres of knowledge and concern; and finally, the goal of health promotion is to break down barriers.

The goal of healthy communities is to strengthen community control of health -- where health is defined as a resource for control over one's life. The value of fostering public participation and democratic involvement in decision making should be extended to the development, identification, selection and interpretation of healthy community indicators. This model of community involvement in planning demands a community development approach. John McKnight (1987) identifies the way in which knowledge is accumulated by the various constituencies.

In Universities, people know through studies. In business and bureaucracies, people know by reports. In communities, people know by stories. These community stories allow people to reach back into their individual experience for

knowledge about truth and direction for the future.

The direction for the future must be to develop models for community involvement in the search for truth about themselves, their communities and their future.

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